Project Compassion
11315 Rancho Bernardo Road, Suite 146
San Diego, California 921 (83
™

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REQUIRED

Application for Medical Day Trip

Please Print CLEARLY

Mission Trip Location: MEXICO Trip Date: _____

Full Name_____ Nickname for name badge_____

Home Address: _____

City/State/Zip_____

Home Phone:_____Cell Phone:_____Work Phone:_____

E-Mail:_____

Date of Birth_____ Age:_____ Gender: Male Female

Passport Number:_____ Date of Issue:_____

Place of Employment:_____Occupation:_____

Do you speak other languages proficiently enough to serve as an interpreter? No / Yes
If YES, please specify:_____

Church regularly attending, if any:_____

Non-medical Personnel: I am interested in participate as a Helping Hand by assisting with

- ❑ Registration ❑ Prayer/ Evangelism, ❑ Translating
- ❑ Crowd Control ❑ Teaching Health Ed ❑ As Needed

(it may not be possible to honor all requests)

Medical Personnel:
Type of License/Certificate:_____ License #:_____
Years of Experience:_____ Sterile Glove Size: **S**mall **M**edium **L**arge

Please Read and Sign:
I agree to conduct myself in compliance with Project Compassion principles and team policies at all times while among the team members, with the hosts and with those whom we serve.
Sign:_____ Date:_____

I give my permission for Project Compassion to publish photos and testimonies that are appropriate and related to the Mission Trip. Sign:_____ Date:_____

™

MEDICAL/LIABILITY RELEASE FORM

(Release of All Claims)

In consideration for being accepted by Project Compassion, Inc. for participation in an event, I do hereby release, forever discharge and agree to hold harmless Project Compassion and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the participant that occur while said person is participating in the above-described trip or activity including recreation and work activities.

Signed this_____day of_____, 20_____.

The undersigned further consents to the administration of first aid and/or doctor's care, or any other form of medical treatment necessitated by illness or injury that may require the same. In the event of the necessity of such care or treatment as heretofore described, the undersigned agrees to hold harmless and indemnify said organization, its directors, employees and agents from any acts of malfeasance, and/or failure to act on the part of those chosen to administer medical care on behalf of the participant.

The undersigned furthermore attests and verifies that he/she is physically fit and has no medical condition(s) that would prevent him/her from performing the volunteer services for which s/he is applying.

Participant Name (please print)_____

Participant Signature:_____

Notify in Case of Emergency:

1._____

Name Relationship Phone

2._____

Name Relationship Phone

Participant's Insurance Company:_____

Policy Number:_____

Do you have any physical limitations? If yes; explain_____

Do you have a history of medical problems requiring on going treatment? If yes; explain_____

Are currently taking any medications? If yes; list_____

Do you have any allergies to food or medications? If yes; list_____

Please list Primary Physician name / phone number: _____